LUMPEN ABUSE AND METHADONE MAINTENANCE

THE IMPACTS OF HIDDEN VIOLENCE ON RETENTION, SATISFACTION AND ABSTINENCE

by

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ABSTRACT

Philippe Bourgois and Jeff Schonberg pioneered the theory of lumpen abuse, expanding on and integrating Marx's concept of the lumpen proletariat, Bourdieu's symbolic violence and Foucault's biopower and Levi's politics of the gray zone. Lumpen abuse as a theoretical lens can reveal a wealth of insight studying marginalized populations. This study looks at the impacts of lumpen abuse and symbolic vulnerability among Denver MMT clients and discusses the hidden forms of everyday violence that impact their retention, satisfaction and abstinence in MMT.

The form and content of this abstract are approved. I recommend its publication.

Approved: Stephen Koester

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CHAPTER I

INTRODUCTION

This is a study about addiction treatment - specifically about methadone maintenance therapy (MMT) - but, below the surface, the themes of violence and agency are always present. A favorite professor from my undergraduate days, while he was coaching me through writing personal essays for graduate school applications, once told me that a good research focus should be like a three-legged stool. It should have a population, a theoretical lens, and a place. My focus over the last couple of years has been the subjective violence that I've encountered in the everyday lives of injection drug users (IDU) living in the Denver-Aurora Metropolitan Area.

This started as a study to assess the effects of lumpen abuse in the culture of the methadone clinic but the level of agency exerted by my informants caught me by surprise. My question evolved from, how does lumpen abuse impact low income/housing insecure MMT clients in Denver, to what is the difference between informants who recognize the structural violence in their lives and resist and those who experience similar levels of structural violence as abuse?

Background and Theory

While there is no shortage of literature on MMT, there are two important works on MMT clients in Denver that cannot be overlooked. In 1999 Koester, Anderson and Hoffer published on the topic of motives of heroin users in engaging with MMT (1999) and in 2011 Al Tayyib and Koester examine another angle by reporting active heroin users' perceptions of MMT as a part of the CDC National HIV Behavioral Surveillance

survey (2011). User motivations and perceptions are of vital importance in MMT where "chipping," – the casual use of heroin or other drugs with one's therapeutic dose of methadone - is common (Koester, et al. 1999). In spite of some of my informants self-reporting being very successful in navigating the social space of the clinic, almost all of them reported the use of illicit drugs while on MMT. This confirms that chipping is still an issue in the MMT client community. How much of an issue it becomes for MMT clients varies depending on how the clinic doctor responds (or doesn't) to a client's "dirty" urine analyses (UA). I have also encountered a range of folk knowledge that active drugs users have about methadone and that discourages some from participating in MMT, much of which overlaps with the perceptions discussed by Al-Tayyib and Koester (2011), Stancliff, et al. (2002), and Goldsmith, et al. (1984). Active heroin users readily talk about the consequences of methadone being a slow metabolized opiate (SAMHSA 2005), e.g., longer, more pronounced, withdrawal, in terms of it, "getting into your bones." Some of the folk knowledge, like that example, fit with medical and pharmacological understanding but with other folk knowledge, such as methadone rotting one's teeth, I cannot find any medical explanation for. Regardless, in a system where many of the participants are participating of their own volition, their understanding of the system is crucial to the success.

Much of the theory that contributed to the perspective of my research comes from Philippe Bourgois and Jeff Schonberg's book *Righteous Dopefiend* (2009), either directly or by way of the literature that they cite in building their theory of lumpen abuse. With clarification from other works by Bourgois (Bourgois 2000; Bourgois, et al. 2009; Quesada, et al. 2011), I've come to understand lumpen abuse as the reproduction of the

symbolic and structural violence experienced by IDU, MMT clients and other structurally vulnerable populations (Quesada, et al. 2011) in ways that create abuse of themselves and those around them (Bourgois, et al. 2009). Bourgois builds this theory on the work of Marx, Bourdieu, Foucault, and Primo Levi.

Marx provides the groundwork for a theory of lumpen abuse in his description of the lumpen proletariat as a social class. In *The German Ideology*, Marx refers to the lumpen proletariat as "ragamuffins," and "ruined proletariat" (Marx, et al. 1998). He calls the state of the ruined proletariat, "the lowest level to which the proletarian sinks who has become incapable of resisting the pressure of the bourgeoisie" (Marx, et al. 1998). This use of lumpen, which literally translates from German as rags or tatters, lends itself perfectly to an analysis of structural and symbolic violence. Bourgois and Schonberg describe over and over again their informants' inability to resist pressure from the groups they encounter like the California Transit Authority who would evict them and pay them to cut down the brush that provided cover for their camps, and the small employers who exploit their addicted bodies for cheap, on demand labor (Bourgois and Schonberg 2009). For Marx this inability to resist is a part of their class but it overlaps with and is a part of the types of hidden violence that they experience.

Before we can begin to address structural and symbolic violence and the role of it in my research we need to redefine violence. There are two large groupings of violence. The first is the kind of physical assault on a person that we most commonly associate with the term violence; the second, is a more insidious kind of violence that is often hidden and misrecognized. Philosophers like Slavoj Žežek define these as subjective and objective violence (2008). Subjective violence is the violence most easily recognized; it is

the interpersonal, often physical, violence that is easily recognized and agreed to such as the physical assault of a person. Objective violence encompasses what anthropologists commonly refer to as hidden violence. Structural violence is the largest category contained within objective violence and the category in which the other forms of violence/abuse that I look at are nested. Bourgois and Schonberg (2009) utilize Paul Farmer's definition of structural violence, "How the political-economic organization of society wreaks havoc on vulnerable categories of people," (Bourgois, et al. 2009; Farmer 2003; Farmer, et al. 2004) but I feel like Žižek's definition of the whole of objective violence also lends insight.

> *It is seen as a perpetuation of the 'normal' state of things. However, objective violence is precisely the violence inherent to this 'normal' state of things. Objective violence is invisible since it sustains the very zero level standard against which we perceive something as subjectively violent.* (Žižek 2008)

This violence created by the structural inequalities of society, reinforces discourses that inequality is the natural order of things (Bourgois and Schonberg 2009; Singer 2008). Misrecognition of the cause of violence against the structurally vulnerable by the structurally vulnerable is symbolic violence (Bourdieu 2000; Bourgois and Schonberg 2009). Bourgois defines symbolic violence as, "The mechanism whereby the socially dominated naturalize the status quo and blame themselves for their domination" (2000). Bourgois and Schonberg discuss the usefulness of symbolic violence as a concept for understanding homeless drug users because of the level to which drug use and poverty are commonly attributed to character flaws (Bourgois and Schonberg 2009). In my experience with MMT clients, symbolic violence is a crucial element of their everyday

experience as they attempt to navigate the social space of the clinic. Time after time during interviews I listened to MMT clients tell me how they knew the clinic's rules and their unsustainably low dose or inability to get phases (privilege levels) or a variety of other small incidences of violence they endure were really their own fault instead of the result of one of the myriad of forms of violence against the structurally vulnerable created by structures working as intended.

An example of this comes from my informant Mark. His dose of methadone at the time of our interview wasn't enough to avoid withdrawal in the early mornings before the clinic opened. He had been at a functional dose earlier in his treatment and other MMT clients widely reported that doctors in the clinics have discretion to work with clients in determining a functional dose, but Mark's dose was reduced because of testing positive for benzodiazepines – a popular class of drugs among MMT clients because of their effect in compounding the otherwise minor euphoric effects of methadone. The same compounding effects could result in an overdose and so the reduction of Mark's dose was framed as a step taken for his own safety and health. Nevertheless it also reduced Mark's ability to stop taking benzodiazepines because he needed them now to counter the effect of the withdrawal symptoms he was feeling. The use of health discourses as a mechanism to construct fault in Mark's low dose and daily experience of opiate withdrawal is a textbook operationalization of Foucault's concept of biopower (1978). It also integrates biopower with symbolic violence. Foucault writes about the shifting of forms of governmentality from threats of death and state violence to regulation of a person's biological state; enforcement by regulation of life (1978). While Foucault uses the dichotomy of control by death and control by life, this is commonly interpreted

in the way that Bourgois and Schonberg use which is the shift between "bloody repression," to control through promotion of health and well-being (2009).

Lastly Bourgois and Schonberg turn to chemist turned social theorist and holocaust survivor Primo Levi for the theory of the politics of the gray zone. Through his experiences of extreme life and death situations in Auschwitz, Levi came to the idea of a special politics of morality in what he called the gray zone. In his book *The Drowned and the Saved*, he discusses the near guarantee of death in the camps without some form of special status and how that created sub-hierarchies among the oppressed (Levi 1989). Those at the top of such hierarchies of the lumpen had much more to lose than their oppressors and were often more vicious than the Nazi guards in the camp and yet Levi says that we cannot judge the abuses of these persons (1989). He writes that it is impossible to tell how one would react in the extremity of the gray zone until one has survived in similar situations of life and death (Levi 1989). Bourgois and Schonberg write that, "In the gray zone, survival imperatives overcome human decency as inmates jockey desperately for a shred of advantage within camp hierarchies, striving to live just a little bit longer" (Bourgois and Schonberg 2009). While the day to day lives of Bourgois and Schonberg's homeless heroin users or my low income MMT clients are hardly on the scale of Auschwitz, Bourgois and Schonberg say that looking at the social spaces they navigate as micro-gray zones helps us to reveal the coercion and suffering that is an everyday part of their lives (Bourgois and Schonberg 2009).

Purpose of Study

The purpose of this study is to seek to apply the theory of lumpen abuse to the study of MMT, asking, what is the impact of lumpen abuse on agency, resistance and

harm reduction in MMT while building on Koester, Hoffer, Anderson and Tayyib's previous work on the agency of MMT clients. Bourgois and Schonberg provide a cursory discussion of methadone and introduce some of the problems in MMT, but this discussion isn't focused on the impacts of hidden violence and lumpen abuse on treatment in the way that I pursue it here. They reiterate many of the structural issues that Bourgois writes about in "Disciplining Addictions: The Bio-politics of Methadone and Heroin in the United States" (2000) such as restrictions on time and place of dosing that limit one's functionality in everyday life, sometimes punative dosage levels, wildly varying dosage levels and availability from region to region, high cost and little public support – financially or morally (Bourgois 2000; Bourgois and Schonberg 2009). This study's narrower focus seeks to apply lumpen abuse to MMT specifically and always with an eye out for ways of improving the overall experience of MMT clients.

Methods

The formal portion of this study involved ethnographic interviews with nine respondents focusing on their daily experiences at the methadone clinics they attend. The interviews probed for types of hidden violence that the informants experienced or enacted via lumpen abuse. Through the course of the study I found that the best way to do this was to begin by asking respondents about their daily routine at the clinic and then progress to more and more specific questions about people they see at the clinic, both clinic employees and other clients, and then end with questions specifically about community and objective violence. In addition to ethnographic interviews participants were asked to answer a brief set of quantitative questions (face sheet) to provide

demographic data for the sample, things like age, ethnicity, income sources and housing situation.

I also conducted two key informant interviews in this part of the study. The first key informant interview was with a doctor who was instrumental in founding the first methadone clinic in Denver - Don Egan, MD. This interview helped to get historical context and also to get the perspectives of a professional working with MMT clients in Denver. The second was with a Blake. She is a woman who has many roles in the IDU and MMT communities in Denver. She works with a number of organizations, one of which helps MMT clients and opiate users who are seeking MMT to pay for MMT. She is also a long term MMT client. Because of her status as a current MMT client and the portion of the interview that was dedicated to her experiences as an MMT client, her interview is grouped with the other informants while that of Egan is used mostly for background, not coded or analyzed.

I also draw on field notes and experiences with observing clients of the largest syringe access program in Denver – the Harm Reduction Action Center (HRAC). It was through participant observation I identified the impacts of hidden violence on MMT as a harm reduction and health issue among IDU in Denver. While only a fraction of HRAC clients are currently MMT clients, my field notes and experiences at HRAC were important to my understanding of MMT.

Summary

This work looks at the impacts of types of hidden violence including lumpen abuse on the agency of MMT clients in Denver. Within this group of hidden types of violence are structural violence, symbolic violence, and lumpen abuse, each of which is

nested in the previous (Bourgois, et al. 2009). Structural violence is the violence that occurs when structures are functioning properly (Bourgois, et al. 2009; Farmer 2003). Symbolic violence is the violence that is experienced when structural violence is misrecognized as being the result of some fault or defect of the experiencer (Bourdieu 2000; Bourgois and Schonberg 2009; Bourgois, et al. 2009). While all MMT clients that I have interacted with have experienced some level of structural violence as a part of MMT, not all experience the same levels of symbolic violence and some are more effective than others at resisting structural violence. In the pages that follow I will go into greater detail to explain the implications of hidden violence on the outcomes of lumpen abuse or agency. I will then discuss in greater detail my methods and findings ending with the implications of this theoretical lens on my findings and vice versa.

CHAPTER II

THEORY & CURRENT LITERATURE

In this chapter I will flesh out the theory that led to my interest in this topic and guided the analysis of my data. The conceptual framework for this study is based on Bourgois and Schonberg's theory of lumpen abuse and in this chapter, I discuss the major theorists that influenced their theory - Marx, Bourdieu, Foucault, and Levi - concluding with a discussion of the relevant current literature connecting that body theory to MMT or drug addiction services in general.

My findings are not limited to lumpen abuse as Bourgois and Schonberg described it though. While Bourgois and Schonberg dismiss the use of the standard academic dichotomy of agency and structure to analyze drug addiction and homelessness, the topic of agency was unavoidable with my participants. While I was primarily interested in gauging the presence and impacts of lumpen abuse in early interviews, incidents of agency and even effective resistance to the structural violence of the clinic emerged in the responses of my participants. Not only was the topic of agency unavoidable but the integration of these topics with the complex other elements of the theory of lumpen abuse enriches it and creates new meaning in the everyday negotiations of social space in the lives of MMT clients. The last section of this chapter will be devoted to bringing this body of literature and diverse theory together and making the argument for the integration of a theory of agency in the theory of lumpen abuse as currently defined.

On Lumpenization

The inclusion of Marx in building a theory of lumpen abuse does two things; it describes the population of the study as a social class – introducing all of the power dynamics of class conflict, and discusses the aggregation of persons outside of the means of production that creates the lumpen class, i.e. lumpenization or what Bourgois refers to as "lumpen subjectification" (Bourgois and Schonberg 2009). In *The German Ideology*, Marx refers to the lumpen proletariat as "ragamuffins," and "ruined proletariat" (Marx, et al. 1998). Looking at a German edition of the text (1932), distinction is made between these two terms. In the first section that describes the lumpen proletariat as a class and the process of lumpenization, Marx uses the terms, "ruinierten Proletariern" and "Lumpen," to distinguish between what is commonly translated as the ruined proletariat and ragamuffins (Marx 1932; Marx, et al. 1998). Specifically, in this section, he refers to, "einer Kollektion von Lumpen," which translates directly to, "a collection of ragged" (Marx 1932). The importance of this distinction to the text is apparent when Marx goes on to say that the lumpen (capitalized in the German but not in English because it is German practice to capitalize all nouns rather than just proper nouns) have existed in all ages and predate the formation of the proletariat. Thus, by using two terms to describe the lumpen they can be both ruined proletariat and the ragged although both are clearly labeled as part of the lumpen proletariat. This indicates some fluidity in class borders - no matter how viscous that fluidity might be - at least for downward movement. The lumpen predate the mass formation of the proletariat and the ruining of the proletariat creates lumpen.

> *Hence the entire proletariat consists of ruined bourgeois and ruined proletarians, of a collection of ragamuffins, who have existed in every epoch and whose existence on a mass scale after the decline of the Middle Ages preceded the mass formation of the ordinary proletariat.* (Marx, et al. 1998)

He also suggests this movement when he calls the state of the ruined proletariat, "the lowest level to which the proletarian sinks who has become incapable of resisting the pressure of the bourgeoisie" (Marx, et al. 1998). This movement implies a process of lumpenization by which persons acquire the "disposition" (Bourdieu 2000) which predisposes a person to the misrecognition of the cause of violence against them which is inherent in the symbolic violence I will discuss in the next section (Bourdieu 2000; Bourgois and Schonberg 2009; Bourgois, et al. 2009).

While these examples suggest a certain ambiguity in terms of Marx's attitude or sentiment toward the lumpen class, Bourgois and Schonberg use one of Marx's more colorful descriptions of the lumpen in which he says they are the, "scum, offal, refuse of all classes" (Bourgois and Schonberg 2009; Marx and De Leon 1898). Marx viewed the lumpen as the "historical fall-out of large-scale, long-term transformations in the organization of the economy" (Bourgois and Schonberg 2009). Bourgois and Schonberg look at the historical context and current social structure that leads one to be socially vulnerable and keeps them socially vulnerable (Bourgois and Schonberg 2009). It is one thing to study socially vulnerable populations but if one simply looks at the lumpen without examining the process that led to their condition then we are guilty of what Bourgois and Schonberg call a "voyeuristic pornography of suffering"(Bourgois and Schonberg 2009; Bourgois, et al. 2009). When I study vulnerable populations that make

up the modern lumpen I benefit from what members of this class share with me. By asking hard questions about lumpenization like what the causes of lumpenization are; what makes a person structurally vulnerable or, as is the case with MMT, what makes one person more vulnerable than the next to the symbolic violence that inhibits their capacity for resistance, I have the opportunity to look for solutions and the potential to also benefit my participants.

Symbolic Violence

In the hierarchy of hidden violence, one must define structural violence in order to properly define symbolic violence. The interplay of these two begins with structural violence as a foundation and without fully fleshing out a theory of structural violence there can be very little understanding of symbolic violence. Structural violence is the category within which the other forms of violence I looked at are nested.

There have been a number of social theorists who have weighed in on structural violence. Paul Farmer contributed greatly to its study in anthropology and his definition is the one used by Bourgois and Schonberg in building a theory of lumpen abuse but the origin of the term 'structural violence' comes from Galtung (Bourgois, et al. 2009; Farmer, et al. 2004; Galtung 1969). Galtung discussed the subjectivity of definitions for terms like peace and violence. His working definition of violence, which includes both subjective and objective violence, fits perfectly into any discussion of violence; "Violence is present when human beings are being influenced so that their actual somatic and mental realizations are below their potential realizations" (1969). While this definition is broad, it is sufficient to encompass almost any kind of violence and still limited enough to avoid reaching into situations where the presence of violence would be questionable.

Using peace as polar binary for violence, Galtung argues that if one takes a narrower definition of violence, and keeps peace defined as the absence of violence, then too many undesirable social arrangements are included as peaceful (1969). This would include things like sexual or emotional abuse that, while they might have physical manifestations, do not always induce direct physical harm. Galtung is also careful to avoid defining unavoidable things as violence. He uses the example of tuberculosis, saying that a death from tuberculosis in the eighteenth century could hardly be considered violence but a death from tuberculosis with today's medical science is so avoidable that it is clearly violence (1969). This is all the more a poignant of an example today as states of indisputable structural violence in prisons spread drug resistant tuberculosis. Galtung's definition of violence by juxtaposing it with peace could also fit with juxtaposing violence with Baer, et al.'s definition of health, "A critical approach must define health as access to and control over the basic material and non-material resources that sustain and promote life at a high level of satisfaction (1986)."

Galtung recognizes six dichotomies in violence as illustrated in figure 1. The dichotomies are intentional or not intentional, manifest or latent, physical or psychological, with or without objects, seeking positive or negative influence and personal or structural.

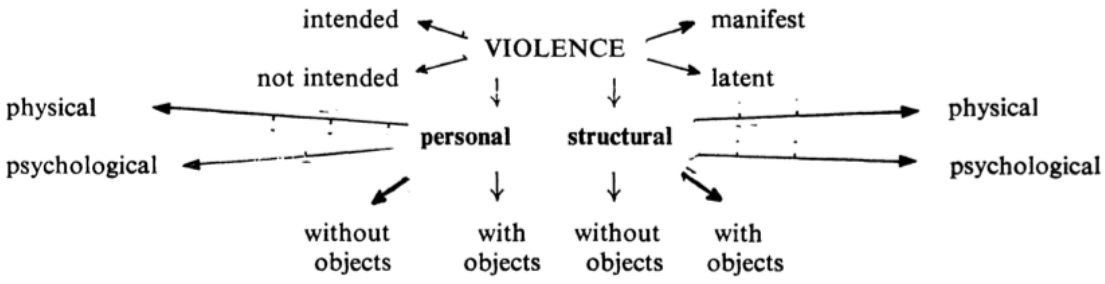

Figure 1: Galtung's six dichotomies of violence (Galtung 1969).

For the purpose of defining structural violence, the dichotomy to pay attention to is between violence with or without subjects. First, to explain the language, Galtung structures the anatomy of violence in the same way that we structure a sentence. He talks about violence as having a subject, object and an action (1969). The subject is the actor – the perpetrator of violence. The object is the person acted upon – the recipient of violence or victim. Violence can occur with or without an object because violence can be acted out against a thing and still serve as damaging to a person associated with that thing; the owner or person otherwise symbolically represented (Galtung 1969). Violence can also occur with or without a subject. With or without subject isn't represented in figure 1 as a dichotomy because this is what Galtung uses as the definition of structural violence. When violence is enacted with a subject – by a person- then it is said to be personal violence; without a subject, violence is enacted by the structures in place and is thus called structural violence.

> *We shall refer to the type of violence where there is an actor that commits the violence as personal or direct, and to violence where there is no such actor as structural or indirect. In both cases individuals may be killed or mutilated, hit or hurt in both senses of these words, and manipulated by means of stick or carrot strategies. But whereas in the first case these consequences can be traced back to concrete persons as actors, in the second case this is no longer meaningful. There may not be any person who directly harms another person in the structure. The violence is built into the structure and shows up as unequal power and consequently as unequal life chances.* (Galtung 1969)

Bourgois also focuses on the inequality that causes structural violence and is in turn caused by structural violence in his definition, "Political-economic forces, international terms of trade, and unequal access to resources that limit life chances" (2009). This leads into the definition of structural violence that Bourgois provides us from Farmer; "How the political-economic organization of society wreaks havoc on vulnerable categories of people," (Bourgois, et al. 2009; Farmer 2003). Farmer himself references structural violence's heritage in liberation theology when he wrote:

> *Structural violence is violence exerted systematically—that is, indirectly—by everyone who belongs to a certain social order: hence the discomfort these ideas provoke in a moral economy still geared to pinning praise or blame on individual actors . . . We will therefore need to examine, as well, the roles played by the erasure of historical memory and other forms of desocialization as enabling conditions of structures that are both "sinful" and ostensibly "nobody's fault."* (Farmer, et al. 2004)

Hence, structural violence is based on an idea of violence that includes all avoidable limitations, physical or psychological, on a person's potential (Galtung 1969); is acted out by societal structures in a way that is difficult to trace to any one individual and thus appears to be without subject (Farmer, et al. 2004; Galtung 1969); often appears to be "nobody's fault" (Farmer, et al. 2004); can be influenced by very large, international, macro-structures (Bourgois, et al. 2009); primarily afflicts the structurally vulnerable (Bourgois and Schonberg 2009; Quesada, et al. 2011); and is always related to inequality in access to power and resources (Bourgois and Schonberg 2009; Bourgois, et al. 2009; Farmer 2003; Farmer, et al. 2004; Galtung 1969).

Now, what separates structural from symbolic violence? Bourgois defines symbolic violence as, "The mechanism whereby the socially dominated naturalize the status quo and blame themselves for their domination" (2000). The theory comes to us from Bourdieu. He posits that any violence can have a symbolic dimension and if there is domination in any form there is a symbolic dimension in the "cognitive structures capable of being applied to all the things of the world, and in particular to social structures" (Bourdieu 2000). This means that there can be a symbolic layer to any incidence of violence, but what defines symbolic violence is the additional act of violence that occurs in assigning blame for the violence on its object. This self-blame that often occurs as a result of internalizing and naturalizing structural violence is an act of violence on a symbolic level. Galtung discusses structural violence as being problematic in a society that assigns blame by intent because of the lack of intent that is common in structural violence (1969); this can be frustratingly compounded in symbolic violence. At times describing symbolic violence to non-social scientists, I run into questions like 'who's to blame for that?' or even further victim blaming in the Western cult of positivity when they mistake the meaning to be, 'So it's all in how you interpret your situation?' Bourdieu discusses symbolic violence:

> *Because dispositions are the product of the incorporation of objective structures and because expectations always tend to adjust themselves to chances, the instituted order always tends to appear, even to the most disadvantaged, if not as self-evident, natural, at least as more necessary, more self-evident than might be thought from the standpoint of those who, not having been brought up in such*

> *pitiless conditions, can only find them spontaneously unbearable and revolting.*
>
> (Bourdieu 2000)

It is clear from Bourdieu that, while the symbolic layer of violence occurs in a person's 'disposition,' in their internalization of the structures at play in society, they are blameless in this internalization. This is described at times in other work as oppression sickness, a term that also works to establish the blamelessness of victims of this sort of violence (Baer, et al. 2003). The question that comes up in my research is why does one group of my participants see and respond to the structural violence in their lives and the other internalize those structures as natural? The purpose in asking this question is to better understand the process of internalization and misrecognition, and to reduce their occurrence. In chapter four I will discuss numerous incidents of persons who do not internalize and naturalize the structures that abuse them, and instead resist and report a more positive overall experience with MMT as a result.

The question of what makes a person more vulnerable than the next to structural violence is a question that is beginning to be discussed within the context of a theory of structural vulnerability (Quesada, et al. 2011). Quesada, et al. define structural vulnerability,

> *Structural vulnerability is a positionality. The vulnerability of an individual is produced by his or her location in a hierarchical social order and its diverse networks of power relationships and effects. Individuals are structurally vulnerable when they are subject to structural violence in its broadest conceptualization. This includes the interface of their personal attributes—such*

as appearance, affect, and cognitive status—with cultural values and institutional structures. (2011).

This is a topic beginning to be discussed in a few contexts in anthropology such migrant health, harm reduction, and sex work (Ezard 2001; Holmes 2011; Miller, et al. 2011), but has yet to be applied in the context of MMT. In my sample almost all were structurally vulnerable and then there were also those who were uniquely vulnerable to the experience of symbolic violence – symbolically vulnerable. A key question in the chapters that follow will be, what makes those more symbolically vulnerable than the rest?

In a study in London, Lilly, et al. analyze the structures in the methadone clinic that create a large portion of the structural violence experienced on a daily basis by MMT clients (2000). They point out that a disproportionate number of studies on MMT focus on the beginning or outcomes but few look at the day-to-day processes of MMT delivery (Lilly, et al. 2000). What they specifically look at are the relationships between the clinic staff and MMT clients and the impacts of heavy regulation on these relationships. In my study, I look at relationships at the clinic but focus more on the individuals and the individuals' experiences with the types of violence encountered in the clinic along with agency, and resistance.

Another study builds on the idea of looser regulation of the clinics, i.e. generous constraint (Harris and Rhodes 2012). In that study, Harris and Rhodes examine the ways that a sample of London area MMT clients self regulate their methadone consumption to retain a reserve that ensures that they are never at risk of withdrawal symptoms (2012). This strategy was used by some in the study to avoid dangerous situations, such as

sharing needles or equipment or dealing with unfamiliar sources of street heroin, or by others to cope with unforeseen circumstances that could prevent them from getting to the clinic to collect their regular doses (Harris and Rhodes 2012). The focus of this study is on agency. The implication was that more generous constraint would have a positive impact on MMT clients. In my sample there were some who were very interested in more generous constraint and others who relied on the clinic for structure. I asked every participant about generous constraint, and the consensus among my sample was that there was a need for flexibility and discretion on a case-by-case basis that involves and values input from the MMT clients themselves.

Biopower

There are two elements from Foucault that Bourgois and Schonberg work with in building a theory of lumpen abuse. The first is subjectivity, which comes into play in the process I refer to as lumpenization, and the other is biopower as a mode of governmentality. Of these biopower is the one that is more important to understanding the everyday violence (Scheper-Hughes 1993) experienced by MMT clients. The concerns of my participants were more directed at the governmentality imposed on them through the biopower of MMT. Biopower as expressed through MMT is a considerable source of structural and symbolic violence in their day-to-day lives.

Biopower is most recognized in medical anthropology in the use of health discourses as a mechanism for control. Foucault describes it with the dichotomy of control by death and control by life (1978). In the eighteenth and nineteenth centuries the dominant form of governmentality shifted from threats of death and state violence to regulation of a person's biological state, i.e. life (Foucault 1978). Foucault discusses this

by writing about the right of a sovereign to decide life and death at one point in history having the totality of, "the father of the Roman family[,] the right to 'dispose' of the life of his children and his slaves; just as he had given them life, so he could take it away" (1978). This total control by death would be worn away until it was limited to the right to require citizens to wage war, thus risking death, and to take the life of those who break the law (Foucault 1977; Foucault 1978). In this form, the sovereign's right to decide life or death was enacted entirely by killing or not killing. This is the control by death side of Foucault's dichotomy. In our post-enlightenment times, while governmentality by control of death is still present in the judicial system, we have largely shifted to control of life through biological states as a mode of governmentality: "One might say that the ancient right to take life or let live was replaced by a power to foster life or disallow it to the point of death" (Foucault 1978). Even in the courts the right to allow life or take it away has been worn away to the point where the vast majority of governmentality exercised therein result in taking life by taking liberty (Foucault 1977), i.e. imprisonment, rather than actual death. What little capital punishment is left is maintained largely on the justification of maintaining the life of others and great efforts have been taken to avoid the old spectacle of the execution – the deprivation of life is now a very private matter between the state and the condemned.

> *Hence capital punishment could not be maintained except by invoking less the enormity of the crime itself than the monstrosity of the criminal, his incorrigibility, and the safeguard of society. One had the right to kill those who represented a kind of biological danger to others. (Foucault 1978)*

When Foucault calls biopower the "power to foster life or disallow it to the point of death" (1978) that holds symbolic and physical dimensions (Foucault 1977). The governmentality of biopower allows for the subjectification of healthy bodies by setting discourses on health and healthy habits that are then internalized symbolically or by depriving the subject of liberty via forced inclusion (Foucault 1977; Foucault 1978), a concept that is not limited to the prison, but also the asylum and drug rehabilitation centers. Of the former, MMT and the newly emerged therapeutic courts are the most symbolic in their exertion of control. I will only touch briefly on therapeutic courts here because they do not bear heavily on my research but for more on them and their impact as social control see Becket and Herbert (2009). Therapeutic courts are any of a number of judicial programs like drug courts that force the internalization of society's dominant healthy bodies/healthy minds subjectivity on defendants sent there through normal judicial process as an alternative to, and utilizing the threat of, imprisonment. They place requirements on their subjects like attending regular meetings that reinforce dominant discourses on healthy bodies/healthy minds and regular UAs. Through absolute authority therapeutic courts are able to force the dominant health discourses on their subjects with direct threats of deprivation of liberty in a way that can hardly be matched anywhere else in society. In the methadone clinic a subjectivity is imposed with rules and medical knowledge reinforcing often punitive measures enforced for the client's own health. Such is the case for Mark who I discussed in chapter one. His dose is too low to prevent withdrawal and so he supplements it with benzodiazepines, and because of the risk of overdose caused by the benzodiazepines, the doctor at his clinic will not raise his dose. The absolute and logical authority conferred by biopower in such an environment makes

it nearly impossible not to internalize and naturalize the violence done to Mark. These special courts and MMT often impose a level of control similar to that exercised by imprisonment but without the walls. The prison guard is symbolically represented in the internalized panopticon (Foucault 1977).

The exertion of biopower in MMT is well documented in the literature. In Disciplining Addictions: The Bio-Politics of Methadone and Heroin in the United States, Bourgois critiques MMT as a system for shifting the unruly heroin addict into a productive subject (2000) by criticizing the stigma placed on pleasure in western biomedicine. The paramount reason within biomedicine for the difference in perceptions between methadone and faster acting opiates such as morphine and heroin, according to Bourgois, is pleasure (Bourgois 2000). Methadone is a slow metabolizing drug, introduced into the body in the slowest metabolizing fashion, oral consumption, and it only stimulates one site on the opiate receptors in the brain rather than the three stimulated by heroin, resulting largely in the loss of pleasure (SAMHSA 2005). This effect and has the therapeutic value of allowing the MMT client to consume only one dose per day rather than the several injections an active heroin user would require to avoid withdrawal and reduces the process of increasing tolerance over time (Bourgois 2000; SAMHSA 2005). The slower metabolization of the drug also means prolonged withdrawal (Bourgois 2000; SAMHSA 2005). Bourgois outlines this and other negative impacts of methadone addiction with examples from a MMT client informant of his called Primo. He cites the numerous downsides experienced by Primo including being tied to his clinic for his daily dose which impacts his employment and ability to pay for treatment, and over fatigue from punitively high dosing (if a user is found to continue

using illicit drugs, often doses are increased). He also cites drastic differences in the application of MMT across the country depending on political disposition and predominant beliefs about methadone in a locality; these are often inconsistent with federal recommendations or medical science (Bourgois 2000; SAMHSA 2005). While this is a great macro-critique of the structures that enforce biopower in MMT it doesn't entirely address the hidden forms of violence and the vulnerabilities to that violence that my research looks at.

In Germany, Victoria Bergschmidt asks, "What exactly is so threatening about heroin users?" (2004). In this she refers to modern, biopower, constructions of heroin users as dangerous; as spreading HIV and other infectious disease. This discourse puts heroin users in the power of medical systems by making it a medical problem. Bergschmidt argues that, in light of these discourses, MMT is normalizing; it is society flexing its right to control life by bringing an unhealthy, dangerous, subject back to normal, productive, subjectivity. What Bergschmidt's study doesn't account for lies in the difference between the U.S. and German systems. While I agree with Bergschmidt, she doesn't take into account lumpenization and the need not only to normalize subjects from their dangerous health behaviors but also their dangerous economic states. In my research this problem comes up several times when dealing with participants who, thanks to MMT, now have no need of heroin but also have no safe place to sleep, stable source of income, or means to acquire either of those. With the German welfare system, base physical needs seem to be accommodated for efficiently negating the need for additional discussion, but, in my research, networking with other resources to deal with more than just their drug dependence is crucial to many of my participants.

Politics of the Gray Zone

The gray zone originated in the privileged space between guards and inmates in the concentration camps of Nazi Germany; the Kapos and special work crews among other cases. Levi wrote about the gray zone as the social space created by inmates reproducing the immense structural violence that they suffered under in pursuit of the shreds of privilege that meant the difference between life and death in the camps (1989).

> *The ascent of the privileged, not only in the Lager but in all human coexistence, is an anguishing but unfailing phenomenon: only in utopias is it absent. It is the duty of righteous men to make war on all undeserved privilege, but one must not forget that this is a war without end. Where power is exercised by few or only one against the many, privilege is born and proliferates, even against the will of the power itself* . . . [in the camp] *the hybrid class of the prisoner-functionary constitutes its armature and at the same time its most disquieting feature. It is a gray zone, poorly defined, where the two camps of masters and servants diverge and converge. This gray zone possesses and incredibly complicated internal structure and contains within itself enough to confuse our need to judge.* (Levi 1989)

For Levi in his experience of the camps, privilege literally meant life or death. Without the additional calories that could be garnered with some degree of privilege, prisoners would waste away in a few months (Levi 1989). And so, while Levi says that "to make war on undeserved privilege," is the "duty of righteous men," one must weigh such statements against the "incredibly complicated internal structure [that] contains within itself enough to confuse our need to judge (1989)." In this, the gray zone becomes a

space that warps all attempts to apply moral structures. Behavior in the gray zone is complex, responding to intense external pressures and violence. To apply the concept of the grey zone to lumpenization allows a more complex interpretation of the everyday violence that homeless drug users reproduce among their closest social cohort, which explains Bourgois and Schonberg's incorporation of it into the theory of lumpen abuse. This is better illustrated by the heroin user Tony from Singer's *The Face of Social Suffering* (2006). Through Singer's documentation of Tony's life there are numerous examples of the unique morality of the gray zone as Tony does what he sees as necessary to avoid the wrath of an abusive father and the everyday violence of jails, prison and street life.

Within my sample the gray zone is most manifest in finding that, rather than defined and cohesive social groups among MMT clients, I found what Levi calls a "thousand sealed off monads" (1989). He writes about how, upon entering the camp expecting to find the camaraderie of us against them, what one found instead were enemies on all sides, vying for the privileges needed to survive (Levi 1989). Among my participants this solitude is a common survival tactic for avoiding some of the pitfalls of the clinic – relapse, drug dealing and hustling. While one might expect to find the greatest advantage conferred to those who band together against the structures acting on them to work together for better treatment and greater access to resources, this wasn't what played out. In fact, those with the greatest inclinations for camaraderie often reported the highest vulnerability to symbolic violence. In this way, while the MMT clinic is worlds away from Auschwitz in the actual level of violence, the gray zone is still very useful in analyzing the MMT clinic to show the complex relationships between interpersonal relationships and larger structural coercion. As Bourgois and Schonberg

explain it, “This perspective renders more visible the complex interaction between intimate behavior and larger coercive constraints” (2009).

Agency and Resistance

Thus far I have delved into the pillars of theory that contribute to a working theory of lumpen abuse. Now it’s time to bring them all together and juxtapose them with agency. Bourgois and Schonberg dismiss the old academic structure versus agency dichotomy as, “too binary a conception to explain why people do what they do” (2009). What Bourgois and Schonberg replace agency with is lumpen abuse (2009), but the problem is that not everything fits within the boundaries of lumpen abuse. In Bourgois and Schonberg’s application, lumpen abuse becomes the result of a sort of coercion; the replication of suffering resulting from extreme outside pressures. Some MMT clients are able to act in the own interest without replicating the violence enacted on them and, at times, even effectively resisting the structural violence in their lives. So the new dichotomy becomes the difference between lumpen abuse and agency.

Building the theory of lumpen abuse there are two types of violence within the social spaces of lumpenization, biopower and the gray zone. These are structural violence and symbolic violence. Structural violence is the broadest of these violence types. The definition I work with here is that of Bourgois and Schonberg, “How the political-economic organization of society wreaks havoc on vulnerable categories of people” (2009). Symbolic violence is the violence that is enacted when the recipient of structural violence misrecognizes that violence often leading to the perception that the violence is a manifestation of the intersection between that person’s actions and the way things are; to quote Bourgois again, “Domination, hierarchies, and internalized insult that are

legitimized as natural and deserved" (2009). And so, structural violence is the harm created by a system, symbolic violence occurs when structural violence is misrecognized and internalized. When symbolic violence occurs in lumpen populations within the social spaces enmeshed in the gray zone and biopower it tends towards the replication of itself in the forms of intimate violence and abuse among members of the population as well as self-destructive behavior. Bourgois and Schonberg define it as,

> *Intolerable levels of suffering among the socially vulnerable (which often manifests itself in the form of interpersonal violence and self-destruction) in the context of structural forces (political, economic, institutional, cultural) and embodied manifestations of distress (morbidity, physical pain, and emotional craving).* (2009)

Operationalizing lumpen abuse as a dichotomy with agency, it seems like the only logical outcome. Symbolic violence combined with biopower means that persons in this intersection of forces are internalizing and naturalizing discourses that the violence they are suffering are not only their own fault, but also for their own good. How does one resist violence directed at control via enforcement of life and health? That's not to say that resistance isn't possible, but it requires the social power to assert one's own discourse in dealing with the dominating structures. To do that one would need to recognize the invalidity of the health discourse of the dominating structures, which would seem impossible while internalizing and naturalizing those same discourses in an act of symbolic violence.

In looking at the body of literature on agency and MMT, there are three recent works of note. The first is from Koester, et al. It looks at active heroin users' perceptions

of MMT (Koester, et al. 1999). Their findings help to establish the gray zone that MMT clients in Denver exist in by discussing some of the stigmatization and negative perceptions of methadone held by active heroin users. The findings also present an argument for generous constraint (Gomart 2002; Harris and Rhodes 2012) by showing legitimate modes and intentions for using methadone that fall outside those acceptable in most clinics (Koester, et al. 1999). This includes motivations like taking a short break from heroin, testing the waters for long-term sobriety, and "managing a habit" (Koester, et al. 1999). It's important to take clients' motivations into account in MMT and the need to better incorporate clients' opinions into their treatment is part of the results from this study but this goes a step further, also taking into account the forms of violence that impact those motivations.

Ning explores the ways in which MMT clients use conformity as a mode of resistance in her study at a Toronto methadone clinic (2005). While this study is highly theoretical in its use and building on Foucault's concept of games of truth to critique the divide between "disciplinary power and resistance," (Ning 2005) it stops short of discussing the impacts of structural and symbolic violence directly and their roles in resistance.

In 2011, Al-Tayyib and Koester published a study of injection drug users' experiences with and perceptions of MMT based on data collected as a part of the Denver site for the CDC National HIV Behavioral Surveillance system (Al-Tayyib and Koester 2011). This study looks at barriers to retention in MMT by looking at MMT clients' experiences with MMT. While this study deals with agency and structural violence in MMT it is largely applied. It addresses the structural violence that impacts

MMT clients, but it doesn't dwell on the symbolic violence that goes hand-in-hand with the structural violence or ask why some MMT clients experience more symbolic violence than others or are better able to resist structural violence than others.

Summary

Bourgois and Schonberg's theory of lumpen abuse contains elements of Marx's class description of the lumpen proletariat, structural and symbolic violence, biopower, and the politics of the gray zone. When symbolic violence is present in a gray zone social space populated by lumpen and impacted by biopower, the symbolic violence tends to be reproduced as abuse towards others within the social group and self-destructive behavior.

CHAPTER III

METHODS

This study was built on information gathered during a year of participant observation at HRAC, Denver's largest syringe access program. I volunteered a minimum of one three-hour shift per week distributing syringes to HRAC clients, a maximum of three, three-hour shifts. This also included occasional outreach shifts that consisted of walking around and through high drug use areas cleaning up used syringes and materials while handing out safe injection supplies (not including syringes as per Colorado law), clean socks, drinking water, snacks and condoms. It was my experience with HRAC that showed me the importance of studying treatment options available to low income IDU in Denver, mainly MMT, and helped me to form my research question. It was also with the help of HRAC staff and rapport built up with HRAC clients that I was able to recruit the majority of informants I interviewed for this study. The data analyzed for the study comes from on-going participant observation as a syringe exchange volunteer, 10 semi-structured interviews and survey data from a short face sheet.

I developed a question guide for the in depth interviews that contained a number of open-ended questions around a few salient themes. In practice, the guide was most useful for keeping the interviews on track thematically; there was always leeway for informants to guide the topic and introduce new areas for discussion. As the interviewer, I moved the questions back to the theme at natural breaks in topic and probed for additional information around my four primary codes, structural violence, symbolic

violence, lumpen abuse and community support. Other codes – agency, avoidance and staff support came organically from conversations in the interviews.

Table 1: Summary of codes used on interview data.

Codebook	
SV	Structural Violence
SY	Symbolic Violence
LA	Lumpen Abuse
AG	Agency
CO	Community Support
CS	Staff Support
AV	Avoidance

Interviews began with simple closed-ended questions about the technical elements of the person's MMT; 'What is your phase level?' 'What clinic do you go to?' etc. These would lead to asking what time they go to the clinic and then what is a normal visit like? Probe questions at this point would look like, 'What are the people in line like?' 'What is the staff like?' and 'Walk me through the process of going to the clinic.' I would probe for primary codes at this point and follow through any topics that arose. I would also ask about support networks. Some sample questions would be: 'Is there a sense of camaraderie in among patients in the line?' and 'Is there much support?' These usually led to conversations about clients who were good to socialize with, those who weren't and how to tell the difference although some informants just flatly asserted that it was never good to socialize with other MMT clients. From there I would ask about what they

thought the clinics in Denver could do better. For many this offered an opportunity to compare different clinics they had been at. Clients often waxed romantic about how great their current clinic is but rarely gave their previous clinics such a high marks. Final questions would be about what the informant liked about their current clinic and what they would change if they could. Interviews averaged one hour.

Clinics described by informants in my sample include Outpatient Behavioral Health (OBHS), Addiction Research and Treatment Services (ARTS), and Comprehensive Addiction Treatment Services (CATS). OBHS and ARTS are publicly funded. CATS is a private methadone clinic. OBHS is a part of Denver Health, a large public healthcare organization. ARTS is a large addiction treatment provider associated with the Psychiatry department at the University of Colorado Denver. There is one other private methadone clinic in Denver, the North Denver Behavioral Health Center. One informant whose MMT fees were being paid by his employer described previous experiences there but for most informants the high fees at North Denver Behavioral Health Center made it inaccessible.

Informants were recruited through two primary sources; either directly by me at HRAC or by reputation based sampling through a HRAC staff member who helps people with MMT intake and works with a local organization that offers limited financial support for MMT intake and fees. All informants were given small handouts with contact information for the study and asked to refer other MMT clients via snowball sampling; three of the 10 participants were recruited this way.

Interviews were recorded and converted to mp3 files. For analysis, these files were listened to and detailed notes were taken. Interviews were coded by linking a given code

with the time it came up in the interview. The parameters used to define a single code were verbal utterances as discussed by Le Compte and Schensul (1999). This allowed for some organic interpretation of what constituted a single instance each code. There were no instances where the uniqueness of an instance of a code seemed questionable but there were instances where a single verbal utterance was coded for multiple things, e.g., an instance of symbolic violence that also involved what appeared to be lumpen abuse. Important quotes and excerpts were transcribed.

Demographics and Face Sheet Data

In addition to qualitative data collected through interviews, I also asked each informant to fill in a short face sheet survey with demographic data included here in tables 2-5.

Informants were mostly male and self-identifying as white. The average number of times in treatment was 7.5 and the average education was 2.1 years in college. Types of treatment utilized by informants in the sample included MMT, inpatient therapeutic communities and outpatient treatment. I initially collected data for 12-step groups like Alcoholics Anonymous and Narcotics Anonymous but had to stop because of unclear boundaries for start/stop of treatment making it unclear the number of times a person had been in 12-step group based treatment.

Table 2: Informant ages, gender, ethnicity, number of times in treatment, and education in years.

	Age	Gender	Times in Treatment	Education	Ethnicity
Blake	34	Female	2	14	White
Kiki	55	Male	7	18	Latino
Jim	55	Male	12	16	White
Jon	52	Male	8	12	White
Mark	48	Male	5	12	White
Ryan	25	Male	5	12	White
Brad	50	Male	6	14	White
Joseph	26	Male	2	16	White
Chad	42	Male	23	15	White
Debbie	50	Female	5	12	African American

Table 3: Types of treatment and number of times for each informant.

Types of Treatment							
	MMT	TC	Outpatient		MMT	TC	Outpatient
Blake	1	1	0	Ryan	1	3	1
Kiki	3	4	0	Brad	1	3	2
Jim	8	1	2	Joseph	1	0	1
Jon	5	3	0	Chad	7	10	6
Mark	3	1	1	Debbie	1	2	2

Table 4: Types of housing.

Types of Housing	
Blake	Apartment
Kiki	Apartment
Jim	Homeless
Jon	Homeless
Mark	Homeless
Ryan	Homeless, With friends
Brad	Apartment
Joseph	Apartment
Chad	Apartment
Debbie	With Friends

Of the sample, 40% reported being homeless or living with friends; the other 60% rented apartments. None reported owning their homes.

Table 5: Types of drugs used in the past 30 days.

Drugs Used Last 30 Days	
Blake	None
Kiki	Marijuana
Jim	Marijuana, Heroin
Jon	Heroin, Benzodiazepines, Alcohol
Mark	Heroin, Benzodiazepines
Ryan	Marijuana, Benzodiazepines
Brad	Heroin, Benzodiazepines
Joseph	Marijuana
Chad	Marijuana, Benzodiazepines
Debbie	Marijuana, Benzodiazepines

Almost all informants, 90%, reported using drugs other than methadone in the last 30 days. This was posed on the face sheet survey as an open-ended question allowing informants to write in any substance they felt belonged on the list.

CHAPTER IV

RESULTS & DISCUSSION

"I get kind of scared because I don't want to get kicked off or I won't have nothing. So, I got to eat crow a lot of the time over there." –Mark.

The focus of this chapter is on the impacts of types of hidden violence including lumpen abuse on the lives of MMT clients in Denver. While all MMT clients that I have interacted with have experienced some level of structural violence as a part of MMT, not all experience the same levels of symbolic violence or lumpen abuse and some are more effective than others at resisting structural violence.

By and large, my findings were quite different from my expectations coming into this study. What I found when interviewing MMT clients was that they were very socially adept people who were often very isolated, but also very aware of the sources of the violence against them. While symbolic violence was present it was often far from the most pressing issue that was reported in interviews. Even among the most symbolically vulnerable, symbolic violence was, at times, coded in interviews side by side with the coinciding structural violence, e.g., "I know the rules but . . ." This phrasing came up often as a way of acknowledging the biopower discourses telling them that the negative situations they were experiencing were for their own good, but refusing to fully accept the naturalization of the violence against them.

While lumpen abuse was often present, the most pressing issue for many respondents was the variety of manifestations of structural violence that came up during interviews and were often the primary concern of the interview in spite of my probing for

incidences of symbolic violence, agency, resistance or lumpen abuse. Yet, even with the near universality of experience of structural violence among my respondents, there were still many incidents where reducing structural violence couldn't be accomplished with a uniform response. What was the bane of one respondent's existence was sometimes exactly what another wanted more of. If there was one universal to come from these interviews it is the need for tailoring of treatment plans to the individual.

Lumpen Abuse

In spite of an abundance of lumpen abuse, most respondents didn't linger on the forms of lumpen abuse they endured. They were much more preoccupied with the structural violence that affected all of them daily. Clients that I interviewed experienced very little symbolic violence as a part of the lumpen abuse that was reported. Even the respondent who was most concerned with lumpen abuse, clearly recognized its roots in the levels of structural violence experienced. Lumpen abuse was still present in all interviews though. The least amount discussed was among those whom were self isolating by using avoidance of peers at the clinic as a strategy of risk reduction. This was a strategy that I found recommended by many of my respondents.

"I try not to associate with people in line . . . just go in dose and leave," Jim, a 55-year-old, college educated, homeless white male who is on his eighth time in MMT, said. Most of my respondents echoed similar sentiments during interviews. "I've had some really bad situations with associating with people from the clinic," Brad, a 50-year-old veteran from New York, said. "At first I was under the assumption that everyone there was trying to get better and, if they've been there awhile, they are better – you know, clean and trying to get clean and all that and that's definitely not the case." The

distinction that Brad alludes to is that, while there are people dangerous to associate with at the clinic, there are also people who are there to "get better." "You've got to just kind of watch it and play it by ear . . . use your street smarts and put it to good use," Brad said. Even the most adamant utilizers of avoidance, throughout the interview, would admit to having at least one friend they could turn to in MMT. Jim was very adamant about the dangers of associating at the clinic saying, "Any smart junkie knows, if he goes to a new city and he's got a habit, go to the methadone clinic . . . that's where the junkies hang out." In the same interview though, he spoke highly of spending time with Jon after dosing, in the cafeteria at Denver Health. "I come here every morning and sit here with my friend," he said during our interview, which was conducted in the same cafeteria. Jon is also homeless. He's a 52-year-old white male who has been in MMT 5 times. His employer is currently paying his MMT fees as part of an exploitative relationship wherein he is on call as a carpenter and handy man 24/7 for $20 per day plus MMT fees and a place to stay.

While the avoidance strategy left some clients isolated, others reported connecting with support networks outside of the clinic. Brad, being a veteran, connected to support groups through the VA including some for PTSD, "Because I have PTSD and, you know, anxiety and trauma, I try to seek out people who have gone through the same stuff," he said. Another respondent, Chad, a 42-year-old, white male from Detroit, reported connecting to 12-step support groups at times and spending a lot of time on internet forums designed for methadone users. "I don't know if support's the right word [to describe the forums] but information-wise," he said, "they have suggestions on withdrawal and a lot of it is just, you know, old wives' tales . . . there's an herb they sell it

in head shops . . . I can't remember the name. It starts with a K, I don't know but it helped me a lot when they dropped me, so I didn't end up using when they dropped me down." The "drop" Chad refers to here is a dose restriction imposed on him for taking prescribed benzodiazepines. This is a problem I discuss more in a later section.

Twelve-step programs can also be a source of stigma; both Chad and Blake reported that there are 12-step groups whose members shame MMT clients as swapping one drug for another but Chad reassured me during our interview that that isn't the stance of all groups and it is easy to avoid the prejudiced ones. Brad and Chad talked the most about avoidance in their interviews, and also were two of the lowest reporters of lumpen abuse.

Of the respondents in my sample, there were three who reported much more lumpen abuse than the rest, Kiki, Mark and Debbie. These same three were the respondents who discussed the highest amount of socializing with other MMT clients giving more credence to the avoidance strategy. Kiki is a 55-year-old, homosexual Latino male. He is on SSI. I've known him for most of my time in Denver. He smokes marijuana to help with pain from an undiagnosed medical problem with his legs that results in occasional bursting of blood that could come from even a small scratch. He has been trying to get the problem diagnosed for the entire time I've known him. Mark is a 48-year-old, homeless white male from New Jersey. Medicaid helps to cover his MMT. He has been using drugs for 25 years. Debbie is a 50-year-old, African American woman. She's been in treatment several times but this is her first time in MMT. She's very optimistic about her experiences so far.

Both Kiki and Mark talked about avoidance of other MMT clients less than the average for the group. In coding the interviews I used the same code for experienced lumpen abuse and speech that indicated the enactment of lumpen abuse. While Debbie talked more about avoidance than Kiki and Mark, the lumpen abuse that she talked about more during our interview was indicative of enacting lumpen abuse rather than experiencing it enacted by others. She also appeared to be exerting a comparatively high level of agency. This could be seen as creating the hierarchies that Levi described in the gray zone (1989). It is possible that Debbie's higher level of agency was contributed to by her exercise of lumpen abuse. Debbie also reported having a very easy time choosing whom to socialize with in the clinic, separating those who are doing well in MMT and those she calls, "predators." "There are the predators that try to suck you in - especially if they think you have money – try to suck you in and like entice you with all kinds of shit and what's really big right now is benzos [benzodiazepines]," Debbie said. Incidents of lumpen abuse that Debbie experienced also fit with the idea of hierarchies in the gray zone. There were clear indicators of lumpen abuse in the way she talked about situations where other MMT clients would attempt to pressure her with benzodiazepines or street drugs. "'Try it, it's good,'" she says one MMT client told her after handing her a bag of heroin. "'I don't have no money.' 'Girl, it's on me,' I said 'Oh, Satan! You ain't nothing but the devil.'" The strategy of saying that she doesn't have any money is one she says she uses often to avoid people who would tempt her with benzodiazepines. The lumpen abuse in situations above is inherent in the undercutting of her success within her MMT program but also explicit in some of the responses she reports to her rebukes. "Oh, you must be on paper," she says is one common response. People often have a hard time

believing that she would avoid getting high otherwise which can be seen as a type of lumpen abuse when it's coming from others in her peer group as it undercuts her likelihood of abstinence, provoking the potential of further structural violence at the clinic and encouraging her enactment of symbolic violence.

Of the three who were most concerned with lumpen abuse, Kiki was the most vocal about it. Kiki also discussed a lot of socializing with other MMT clients – second only to Debbie. While Brad discussed much more community support than both Kiki and Debbie, most of his interview that was coded as such related to community support with groups outside the clinic such as his support groups at the VA and support from family, of which he still had a lot. Kiki and Debbie's coded community support was mostly related to socialization with MMT clients.

Kiki was the most articulate in rationalizing the lumpen abuse in the clinic and attributing it to structural violence. Kiki had a friend with him during our interview.

> *Kiki – I feel that all the shit that should be happening with the therapy and the support groups and all of that, because it's not taken care of, it's coming out like we're lashing out at each other. Because, who else do you lash out to? If you lash out to people who aren't 'in the know' of how it works it's not the same. You know, because they don't understand why you're even going there let alone the politics of standing in line.*
>
> *Friend – Well right, say we're both in there and we're standing in line and I lash out on him, he's not going to kick me out of the program. So it's easier to lash out at him. I'm not going to lash out at the lady behind the counter . . .*

Kiki – You know I find a lot of stupidity and ignorance in line and I feel that the hospital itself perpetuates it somehow by acting the way they do. Like they treat you like shit and then they don't let you – like, it's kind of like, ok, first you're trying to get in and they treat you like shit because, ok, because you know, you got into this situation and whatever, right? For whatever reason but they treat you like shit. Then you, the first day, you talk to all these people who I always feel there's always this little tone, I don't know how to explain it but I'm sure you know what I'm talking about. You've dealt with being an addict, right?

Me – Yeah.

Kiki – You know how, the one that's helping you, there's this certain undertone that you just know that she's judging instead of listening; instead of looking out for you and getting whatever you need to succeed in this situation, that yes it's your fault and you got yourself into, and instead it's kind of like, you know what I mean, like, 'Ewe, you used needles.' Like I didn't realize that I had fucked up. And I feel that when – if – I don't know, that, that, if I, if somebody watches you look at me wrong then you're going to look at me wrong too.

The Politics of Standing in Line

This excerpt covers a couple of points. There is the politics of standing in line and also the recognition of structural violence. Taken at face value Kiki's experience of standing in line seems extreme and out of place with the experience of others in my sample until one accounts for a subtle avoidance that was enacted by many of my respondents. Many like Ryan and Chad don't explicitly report experiencing any lumpen

abuse in the line, but report going to the clinic later in the afternoon. Ryan is my youngest participant at 25. He's a homeless white male, who has been using drugs for 8 years. Among participants who report going to the clinic later, this is sometimes a matter of avoiding the line but whether or not avoiding the line is the intent, it is the result and avoidance of the line accounts for a sharp potential drop in the levels of experienced lumpen abuse reported among my sample. The experiences of the participants in my sample who visit the clinic early in the morning are similar to what Kiki describes, although, even during peak hours, CATS is reported to have less pronounced intensity of the politics of standing in line.

By way of definition, the politics of standing in line could be translated as the politics of the gray zone. Much of the abuse in the line is symbolic of maintaining hierarchies.

> *"There's this guy that, he always goes about the same time as me . . . and like, he hates me because he knows I'm fabulous [Kiki's word for homosexual], right, so he hates me like right away. So he would say shit like, because I would, 'Hey, how you doing?' and I would like go and hug somebody, and he starts up, 'Duh, you better not be cutting in line because I'm so tough and I'm going to like kill you.' And I'd be like, 'Can I first fuck up before you give me the speech?'" Kiki said.*

Violent verbal displays about cutting in line like this one were mentioned by several respondents. Cutting in line can be understood as Levi's, "undeserved privilege," that "it is the duty of righteous men to make war on" (1989). What's more, the verbal display at the slightest inclination that one might attempt to cut in line is a way of

claiming the authority to stop such an action. It is standing one's ground, but in such a way that one is claiming the ground on which authority would stand thus claiming the slight privilege that was a critical part of Levi's description of the gray zone (1989). For some, a little bit of privilege at the clinic, while not lifesaving in the face of otherwise certain death like in Levi's description of Auschwitz, is cripplingly important. This is the case for Mark and Kiki. Neither one is at a therapeutic dose which means that both still report some degree of withdrawal right away in the morning. For Kiki, it is minor – affecting his mood and appetite - and he finds himself using alcohol to attempt to alleviate some of the symptoms and improve sleep. For Mark, there is no alleviating the symptoms without opiates or benzodiazepines. He reported being regularly awakened early in the morning to the intense physical discomfort of the first stages of withdrawal. Getting to the clinic and dosed as early as possible takes immediate priority over any other concern. "Being sick from dope is a bad, bad, bad, bad feeling. You can't eat, you can't drink, you can't sleep," Mark said. "It feels terrible and I'm at that point every morning. I'm there every morning and it's terrible. It's terrible. Unless I get a bag of dope or a shot and get to the clinic on time or get some benzos. It's terrible." For clients in Kiki and Mark's position, getting any slight privilege that might help in dosing fast or alleviating withdrawal, while it may not be a matter of life and death, is all consuming.

Recognition of Structural Violence

The second point covered by the excerpt is the ease with which Kiki sees through the lumpen abuse to recognize the importance of structural violence in it. This was common in discussions about lumpen abuse. While there were participants who mention lumpen abuse as a problem unto itself, most deemphasized its importance.

Deemphasizing lumpen abuse almost always accompanied emphasizing the structural violence in MMT as the primary problem, although sometimes it is masked by the experience of symbolic violence. An example of this comes from my interview with Mark:

> *There's people that will get up there and start yelling at them, 'cause they got a bad day or something. Or the doctor changed their prescription. They'll blame it on the nurse when the nurse has no – it's not their problem. You know what I mean. I've been there long enough to know that they've got protocols and I know all the protocols. From top to bottom, inside out, I know all the protocols that I've got to go through. I know what I've got to go through to get my dose back up. I'm just having a hard time doing it.*

In this example there is lumpen abuse but the emphasis in the story is on the structure of the clinic and the symbolic violence that comes from wanting to work within that structure. This illustrates some of the symbolic violence that is experienced by Mark. "If people would follow them rules it'd be a much better place – a nicer place – to go. It rattles me. I'm getting to the point where unless I can get there and get out real quick, sometimes it can ruin my whole day," Mark said. One could question the lumpen abuse in the excerpt from Mark because the abuse seems to be directed at the nurses and thus outside of the lumpen, or at least outside of the immediate peer group of MMT clients. In that way this might seem like resistance. At the same time though, none of the respondents that I interviewed would have believed that they could affect any positive change by yelling at a nurse. This isn't an act of resistance as much as of the kind of self-destructive exasperation that Bourgois includes in his definition of lumpen abuse:

> *Intolerable levels of suffering among the socially vulnerable (which often manifests itself in the form of interpersonal violence and self-destruction) in the context of structural forces (political, economic, institutional, cultural) and embodied manifestations of distress (morbidity, physical pain, and emotional craving).* (2009)

The abuse against the nurses can also be interpreted as unintentionally abusive against the other clients in line. Mark describes a Saturday scene at OBHS that illustrates this.

> *I get up to the window and I hear the dosing nurses actually like laughing at the clients. Because they do talk a lot of crap about the clinic while they're waiting in line. 'This is stupid waiting. They could have the bottle changed in less than two minutes.' Just let the line go. Please just shut up.*

The last two statements were accompanied by a gesture of complete frustration at the impacts of the comments of those ahead of him in line on the speed with which he is able to dose. Mark is usually experiencing withdrawal before he doses, making the abuse back and forth in the line a superfluous and intolerable delay that keeps him sick while he waits to dose. I found similar levels of frustration in interviewing Kiki. He said, "The people in line are talking shit, the nurses are talking shit, the people in charge are talking shit and you're sitting there and you're like, 'I just want my fucking methadone so I can live my life!'" In both of these cases, while lumpen abuse is what is being explicitly described, there is recognition of the structures at play. The blame might be misplaced in Mark's case, but then the emphasis shifts from recognition of structural violence to emphasizing the symbolic violence. This difference between emphasizing the structural

violence or emphasizing the symbolic violence can partly be attributed to a higher degree of symbolic vulnerability experienced by Mark.

Symbolic Vulnerability

The level of symbolic vulnerability that was apparent once the interviews where coded was not as high as I had expected to find while I was still collecting data but there was still some indication of a degree of symbolic vulnerability. There were two participants in particular who appeared to experience dramatically more symbolic violence than the; Mark and Ryan.

Despite the drastic difference in the amount of symbolic violence that was described in interviews between Mark, Ryan and everyone else, there is no clear, quantifiable, difference that can account entirely for this. Both Mark and Ryan emphasized in their interviews, the perceived importance of structure and understanding the rules and protocols in MMT in order to do well and both indicated that they thought of themselves as doing very well at understanding these rules and protocols.

> *"I've been there long enough to know they've got protocols and I know all the protocols. From top to bottom, inside and out, I know all of the protocols what I got to go through. I know what I got to go through to get my dose back up. I'm just having a hard time doing it," Mark said.*

Ryan expressed a similar familiarity with the structure of the clinic using terms like accountability and consistency, as in, "There's no accountability behind that," about getting Suboxone a month's worth at a time, or, "On Sundays I take it [his Sunday 'take home' dose] very regimentally depending on how the week goes, within that time. I never spread it four hours out because consistency is what it needed. That is why my pupils are

not pinned out all the time now and I can do things in life." He also expressed disappointment when the clinic falls short of this ideal of rigid structure.

> *"I started at 30 mg and you know you doctor yourself a lot as a user, in general. So I put it in the doctor's hands thinking I could trust him. Once I got to see to understand that they are legal drug dealers, 140 mg later they were allowing me to go up based on what I was describing my symptoms as but once I was up to 140 mg I was a vegetable, sleeping close to 16 hours a day. If I was able to, I was – uh, basically it looked like I was on heroin . . . I put it in the doctor's hands and I felt that he exploited me," Ryan said.*

While many clients like Mark would love to be able to increase their doses to a therapeutic level, Ryan felt exploited that the doctor didn't provide the closer, more personally centered medical supervision that he was looking for in his recovery.

Other clients also emphasized the importance of understanding the rules and protocols and yet experience much less symbolic violence. Joseph, a 26-year-old, white male MMT client, and Brad both emphasized the importance of understanding the rules at the clinic but both only showed moderate signs of experiencing symbolic violence.

At the same time, Kiki talked about less symbolic violence than anyone else in my sample and Kiki very openly rejected the idea of arbitrary rules and structure at the clinic. Talking about what he would find ideal at the clinic he said,

> *She [staff at HRAC] treats you like a person. She doesn't care if you didn't brush your teeth and your outfit and your money. She genuinely looks at the person. Well, that's all I would like. If they would just do that [at the clinic], I would be*

the happiest recovering junkie in the history of the world – and I'd write a poem about it! [laughs]

In this statement he indicates that what he wants is someone to look at each case treating MMT clients as individuals rather than applying arbitrary rules. He also laughs about the arbitrariness of the rules when he talks about OBHS's inability to refer for other services at Denver Health even though it is located on the Denver Health hospital campus and is a part of the hospital.

That's why I'm waiting for a primary care doctor, which is so stupid. You know? If I wasn't so sick I'd be laughing really hard. Because, you would think that, uh, you can see the guy's office from yours [shrugs], you'd think. You want to hear something really stupid? If I'm at the clinic and, you know how my leg bursts? Ok, if that happens they have to call 911. So, like, tell me, how stupid are we . . . they cannot bring, even like put me on a wheelchair or whatever and drag me themselves. They have to follow 911 protocol and you're over here and you know, you want to slap them and say, 'You know, there is a hospital right over there!' . . . I mean they wear the same uniform! Their phones are connected! 'I know you are having a baby and you are about to die but I have to call 911 first, because I'm in methadone.'

In general, this sort of mocking of the protocols and rules at the clinic is a dominant theme throughout the interview with Kiki.

A point of departure in particular between Ryan and the rest of the sample was his description of a lot of pressure, internal and external, to see MMT as a very negative, highly stigmatized state. Of his family, he said that his mother had been helping him

with the MMT fees but would be cutting him off in June, only two months away from my interview with him.

> *She believes in me but doesn't believe that I should be on this drug and doesn't feel like she should financially put out and I concur. There's no fucking reason why I shouldn't have my life together by June if not now. So that's frustrating to me – for myself – by myself. I take accountability for almost everything. I'm full of shit about a lot shit still. I'm working on a lot, LOT, of character defects.*

Earlier in the interview he said, "I care a lot about what loved ones think and my sister, she absolutely hates methadone and I've been on Suboxone regimens too. I've tried everything. This is my final straw." Ryan also indicated a lot of self-disgust at his methadone use.

> *Ryan – The run of heroin is an absolute disgusting lifestyle and I hated myself every day. I still feel like I still struggle with the fact that I am becoming what I've always learned to hate.*
>
> *Me- A methadone user?*
>
> *Ryan – Yeah, using methadone as well because I know deep down inside, not listening to my brain, but using my heart in this matter, that I can be a happy, a successful, individual that is a part of this community without the use of any mind altering substance.*

Mark didn't exhibit this level of outside pressure against MMT, but Mark also didn't indicate having any support outside of MMT clients and staff at HRAC. It is possible that he was feeling a similar level of guilt and shame, but directed at himself not because of his participation in MMT but his use of benzodiazepines.

"Eight months, nine months, I was clean. I did no heroin. I did nothing. Ok? Nothing. I was stupid, started doing benzos and my dose went down 10 mg a week until 80 mg and here I am now, stuck in a hole. Have to use benzos. Have to use more dope," Mark said.

Instead of focusing on the arbitrary application of dosage restrictions that, rather than helping him to remain abstinent, forces him to abuse drugs, Mark is left with little option but to dwell on his part in his misery. This isn't for lack of trying. Mark does report in the interview that he has tried to reason with the doctor controlling his dose but hasn't been given any leeway to increase his dose, lessening his need to rely on benzodiazepine use. In order to begin to increase his dose, Mark would need to give two clean UAs. Since UAs are done once per month Mark will have to suffer daily withdrawal for two months, unable to even use between tests because his hepatitis C damaged liver processes the drugs out of his system slower than an average person.

"It's the hardest thing for me man. It really is. If I could do that I'd be good. Really. But it's the hardest thing for me. You know why? Because if I do just a little bit of dope – buy some benzos – I feel so much better. I don't feel sick. My stomach's not fucked up," Mark said.

Other than the symbolic and structural violence suffered by Mark directly because of benzodiazepines, his benzodiazepine situation also reproduces more structural violence in his life.

"I was camping right next door to Denver General, Denver Hospital [OBHS]. I'd get up, I'd cross the street, I'd dose and that was it but I was on a high enough dose where I could tolerate doing stuff like that. You know what I mean?

I could tolerate being out there in the rain and the snow. I can't tolerate it now being so low; I have to have all this shit in me. It's tough man," Mark said.

This isn't to say that Mark's dose should be increased so he can camp in the less sheltered space nearer to the clinic and have a shorter walk in the morning as he implied. It emphasizes the extremity of the additional suffering that Mark experiences because of his dose restrictions. Not only is he stuck in this cycle and suffering withdrawal daily, he is forced to relocate camp and the suffering inherent to sleeping outdoors is magnified.

In the end, this idea of symbolic vulnerability needs more study. It is clear that these two respondents suffer from more symbolic violence, under similar circumstances, than other respondents indicating that there is some degree of special vulnerability. I do not have enough data from this study to draw any solid conclusions as to why though. This topic could easily be another study on its own.

Structural Violence

Structural violence was the most coded for item in all of my interviews. It was present across all demographics. It hit the homeless and the housed, the educated and uneducated alike. The two respondents who experienced the most intense amounts of symbolic violence came from a respondent with a master's degree and one with only a high school diploma. The most common feature of the structural violence that I found among my sample was a failure at the clinics to account for the individual situations of clients. In much the same way that many of my respondents saw past lumpen abuse among their fellow MMT clients to the, "Intolerable levels of suffering," (Bourgois and Schonberg 2009) that lead to lumpen abuse, there were also respondents who saw past the individual actors in the structural violence to the structures that impacted the

individuals. Instead of seeing doctors and counselors unresponsive to their needs, some saw doctors and counselors overloaded with more patients than they could possibly give their full attention to and inefficient systems with poor communication.

The following excerpt is from my interview with Brad just after he finished telling me about his experience transferring between clinics; a process that left him without MMT support for a period of time and resulted in him using heroin to avoid withdrawal.

Me – Is there anything that you feel like the clinic could have done to make the experience better?

Brad – Yeah, definitely. There's like transitions and interpersonal communication between the doctor and the counselor and the patient. Like, at Denver Health, for example, there is hardly any. It's very minimal. There's a lack of. But at CATS it seems so much smaller, smaller clientele. Caseloads for each counselor are less so they can pay more attention to each individual but they are in better communication with the doctor and the patient. So, working there within the clinic is better but I think the clinics in general and the whole state run program needs better communication amongst the clinics altogether.

Me – Do you feel like you have good enough access to the doctors and counselors to get the support you need?

Brad – The counselors, yes definitely, but the doctors, no. They're way understaffed as far as doctors.

Ryan had similar things so say about the staffing at ARTS but about the counselors being understaffed. "My counselor's name was [omitted], he was overloaded with patients; he had 65 which is a copious amount in my opinion," he said.

This isn't to dismiss or excuse the structural violence experienced by the MMT clients in my sample. Of the variety of structural violence that they experienced there were a couple of points that affected a number of the clients. Of these the most universal was the cost of MMT and the risk of fee-tox.

Fee-Tox

OBHS is the cheapest of MMT clinics in Denver. Their fee was $230 per month at the time when I first started talking to Kiki about his MMT as a part of my participant observation in the spring of 2012. Medicare covers approximately half of that for those who qualify. ARTS was reported to have sliding scale assistance but this turned out to be a two tiered fee schedule when I called to confirm. The lower tier for persons with income under $35,000 annually is $230 per month and the upper tier is $300. While this can seem light compared to the approximately $60 per day that many users report spending on heroin – a lot of MMT clients have a difficult time utilizing the same income generating strategies that they did as heroin users.

> *"If you get behind on your payments, their attitude is like, 'Oh, I bet if it was heroin you wanted you would have already, you know –' So you're like, 'Yeah! Let me go shoplift. Let me go scam my neighbor. Let me go work some scam downtown with some yuppie so I can come up with 20 bucks. Like you really want me to do that!'" Kiki said.*

Blake reiterates that sentiment saying,

> *There's always this underlying sort of attitude, even if it's not spoken, it's implied, around 'Well you found money for drugs, why can't you find money for*

your methadone?' Well, because a lot of people can't engage in the behaviors that they did when they were high to make money, now that they are not intoxicated.

Blake was by most standards the respondent who had had the most success with MMT. She's been in MMT continuously since her first initiation, only leaving her initial clinic when it closed. She's been on MMT for over a decade, she works full time, is housed and doesn't report the use of any recreational drugs in the 30 days prior to the interview. In spite of all this, Blake has had problems paying her fees in the past. When asked what helped her to get where she is at, one of her responses was,

I just happened to get very, very lucky. I had a counselor who advocated like crazy for me and we – when they closed down, because I wouldn't have left there, I'd probably still be there except for they got shut down. They kind of went under. And I owed them like $1,800. Between me and my partner we had a major bill with them. But it let me stay in treatment and they kept working with us no matter what and of course we would pay whatever we could whenever and at that point we were always current with our fees we just couldn't start paying on the arrears. But again, like I said, if I hadn't of had that advocate and that support we probably wouldn't have stayed in treatment.

For eight out of ten respondents in my sample the MMT fees are or have been a problem for them; seven report having been fee-toxed.

Chad describes the cost of attending OHBS as the biggest problem he has experienced with methadone. At the time of our interview he had been fee-toxed several times and was working on a planned detox because he could no longer afford to keep paying the fees. "It's going to take me approximately three months to get off of the

methadone without any serious, serious withdrawals. I just can't afford it and so I have to – it's either that or rent," he said.

Table 6: Fee-tox by respondent.

Name:	Fee-tox
Blake	No
Kiki	Yes
Jim	Yes
Jon	Yes
Mark	Yes
Ryan	Yes
Brad	Yes
Joseph	No
Chad	Yes
Debbie	No

Fee-tox was Jon's primary means of exiting MMT for the five times he has been on MMT. "Expense is my biggest problem," he said. When I asked him how he left the first MMT program that he was in he replied,

> *Jon - Probably from losing my job and not being able to pay, being fee-toxed.*
>
> *Me – How often has that happened? You said that you've been on and off of methadone for 10 years now. Is that the only time that you've lost your methadone because you've lost your job?*
>
> *Jon – It's always been because I was unable to pay.*
>
> *Me – How many times?*
>
> *Jon – Now, I have to tell you, I've been on at least five different programs. Some I've been to twice, like this is my second time at Denver Health.*
>
> *Me – And it always goes in a cycle where you lose your job and then are fee-toxed?*
>
> *Jon – Exactly. Yeah. Fee-toxed every time!*

In spite of this history, Jon's overall opinion of MMT was very positive and he was able to exercise an interesting level of agency, even switching clinics when the doctor at his previous clinic restricted his dose for testing positive for benzodiazepines. "You know, I can't really think of too much negative other than having to wait and the occasional counselors or employees that don't show much compassion or caring and the high price are my only beef with the place. Otherwise I think Denver Health is pretty good," he responded without any irony when I asked if there was anything he didn't like about the program he was in currently. "Generally I give them high marks," he said.

The fee-tox system in Denver came about as a compassionate alternative to removal from MMT without detox, but it is insufficient for a withdrawal-free detox. The fee-tox system detoxes an MMT client in 10 days by removing 10% of their dose per day. According to the Substance Abuse and Mental Health Services Administration (SAMHSA) this is to allow the client time to find another program.

> *Whatever the reason for discharge, patients should be made as comfortable as possible during medically supervised withdrawal. Exact schedules require medical determination (see chapter 5), but tapering should be as gradual as possible so that patients can find and enter other facilities.* (SAMHSA 2005)

While the experience of withdrawal can vary client to client, at best, the 10-day detox schedule only allows a few days before symptoms begin to impact the client's ability to function without supplementing with other drugs.

> *"Fee-toxing is awful. It's not humane. It's something that we fought about and for, for a long time because it used to be that there wasn't even a fee-tox situation. You didn't pay there was no dose and I remember those days and those were rough days*

for a lot of people and now you at least have the buffer of a fee-tox and it was designed around what is considered a humane – you know – but really there is nothing humane about it. There's just not. You know, 10 days is for some people enough to get their feet back under them and figure something out but really, you don't have that whole 10 days. You have the first three to four before your dose has been dropped so significantly that you are now incapacitated," Blake said.

Kiki pointed out in his interview that for him there isn't even those few days because the psychological impact of dealing with the inevitability of the withdrawal coming have an immediate psychosomatic impact.

Kiki - That's like the scariest two words in the English language for a junkie. 'You're going to be fee-toxed today.' Oh, you want to slap someone when they do that because you're like, 'Yeah, I finally got in the program and I'm finally pulling it together and now they are going to take it away from me.'

Me – Do they actually use 'fee-tox' at the desk or is it 'administrative detox?'

Kiki – No, it's loud and I mean they might as well put up a screen with a close up because they give you a yellow paper so when you come on up with your I.D. it's like, 'Hi! I'm being fee-toxed today! Hi! Did everyone notice? I'm the one holding the yellow paper. Yes it's true, I'm the one . . . . You're sick immediately . . . because all of the sudden, if you really believe that there is not going to be a way out of it, like your head starts to fuck you immediately.

Dose and Phase Restrictions

Dose and phase restrictions were the other big instance of structural violence that affects a large portion of my sample. Even with the proper medicinal marijuana

credentials a client can be held back from privilege levels and at least one of my participants suffered dose restrictions in spite of having a benzodiazepine prescription. Taken together, these two restrictions affect 7 out of 10 respondents in my sample.

Table 7: Drug restrictions and drug use among all respondents.

Drug restrictions and use				
Name	**Marijuana Restriction**	**Benzodiazepine Restriction**	**Uses Marijuana**	**Uses benzodiazepines**
Blake	**No**	**No**	**No**	**No**
Kiki	**Yes**	**No**	**Yes**	**No**
Jim	**Yes**	**Yes**	**Yes**	**Yes**
Jon	**No**	**Yes**	**No**	**Yes**
Mark	**No**	**Yes**	**No**	**Yes**
Ryan	**No**	**No**	**Yes**	**Yes**
Brad	**No**	**No**	**No**	**Yes**
Joseph	**Yes**	**No**	**Yes**	**No**
Chad	**Yes**	**Yes**	**Yes**	**With prescription**
Debbie	**No**	**Yes**	**Yes**	**Yes**

I've already discussed Mark's situation with benzodiazepines and the symbolic violence that goes with it. Much of the restrictions placed on benzodiazepine use effects the users as symbolic violence. Because of the potentially lethal interaction between benzodiazepines and methadone (SAMHSA 2005) most of my respondents internalized and naturalized the restrictions placed on them regarding benzodiazepine use. The exception to this is Chad. His situation is unique in that he has a prescription for benzodiazepines to treat his anxiety and is still arbitrarily subjected to dose restrictions for testing positive for benzodiazepines in his monthly UAs. "They tell me it's a federal guideline or something but I know that's bullshit . . . I've never had a problem at any other clinic," Chad said. At the time of our interview he was at OBHS but had also been

at ARTS and other clinics in Michigan without any problems with his benzodiazepine prescription.

The participants who talked to me about their restriction for marijuana use all said that they understood it to be at the discretion of the staff at the clinic, but all of the respondents in my sample who used marijuana were restricted with the exception of Debbie and Ryan both of whom had just begun to attempt to get phases; Debbie because she was fairly new to MMT and Ryan because he had just transferred to a new clinic less than a week before our interview. With the topic of marijuana restrictions there was no internalization and naturalization among the respondents who I spoke to about it. The response was often quite the opposite. "I'm kind of rebelling against it. I'll smoke weed just to piss them off because, to me, it's legal in the state of Colorado, and I've got a doctor's prescription so -," Jim said. "And see, it used to be, when I went to the clinic before where you could have weed in your system and it didn't count as a dirty UA."

Joseph reported enjoying the restriction to a small extent. "I mean, for the longest time I didn't want to make it, in my head, I didn't want to make it like too convenient, because once it's just like you're waking up and you're just taking it, it's just like nothing out of the ordinary it just gets too easy on it," he said. Joseph's situation is unique among my sample in that he is not an IDU. He went into MMT after becoming Oxycontin dependent in college and hopes to detox from methadone in the near future. Despite talking about not being entirely comfortable with getting phases, he did say that he would probably try to get phases at some point before his full detox. He said that the marijuana helped him to deal with any discomfort from his slow detox. Joseph wasn't the only

respondent who reported not being comfortable with phases. Jon reported that he didn't want phases because of the stress of having extra methadone around.

> *"My problem is I can resist anything but temptation. If I walk out of there with a bottle sometimes I'll drink it on the spot when it's actually for the next day . . . I need the monitored situation, otherwise I'll fuck it up. Last weekend, the one that just went by, I managed to hold onto my dose until the next day but it was on my mind the entire day. 'Should I drink it now? Should I drink it now? I want it now!'" Jon said.*

There isn't a universal response that will necessarily work to alleviate some of the structural violence that MMT clients feel but these are some points that can be worked on while taking into account client needs and motivations. Clients need more affordable treatment options and greater discretion in dealing with marijuana and benzodiazepine use. Marijuana especially poses no risk to the MMT clinics. There is no possibility of it interacting with methadone. It possesses no documented risk to treatment (Epstein and Preston 2003). Benzodiazepines could potentially lethally interact with methadone but the current system of arbitrary restrictions is encouraging rather than discouraging benzodiazepine use as is the case with Mark. It is also needlessly frustrating for clients with a legitimate prescription like Chad. There needs to be a better way to deal with the potential danger of benzodiazepines.

CHAPTER V

CONCLUSION

The purpose of this study was to seek to apply the theory of lumpen abuse to the study of MMT, specifically asking what are the impacts of lumpen abuse on retention, satisfaction and abstinence in MMT while building on Koester, Hoffer, Anderson and Al Tayyib's previous work on the agency of MMT clients. I did this through semi-structured interviews with 10 MMT clients, utilizing relationships and information from over a year of participant observation at HRAC. One of my participants also works for an agency that helps persons interested in MMT. The form of these interviews was also informed by a key informant interview with a doctor who founded the first MMT clinic in Denver. Interviews were then coded for structural violence, symbolic violence, lumpen abuse, agency, community support, staff support, and avoidance strategies.

Two respondents displayed signs of being symbolically vulnerable and while this didn't seemed tied to any increase in lumpen abuse, it is a source of suffering which merits further study. In my results, there were no conclusive causes of symbolic vulnerability but there were a few possible influences on it. Both of the two informants in my study that were symbolically vulnerable emphasized learning and relying on the rules and protocols that made up the structures of the clinic. Both also experienced a lot of guilt. One's guilt was caused by familial pressures to look down on MMT. The other's guilt was caused by feeling that his dose restriction because of benzodiazepine use was entirely his fault. Overall the idea of symbolic vulnerability is one that needs more study.

Overall, I found less of an association between lumpen abuse and symbolic violence than I had expected to find and much less of an interest in lumpen abuse among MMT clients than I expected to find. I also found an unexpected level of awareness of the structural violence that was impacting my informants. Even the informants that were suffering the most lumpen abuse recognized the structure of the clinic as the indirect cause of that lumpen abuse. The result of this was that the most important topics to many clients were structural issues at the clinic that created structural violence. Two issues that affected my participants more than any other were restrictions resulting from dirty UAs and the cost of MMT/risk of being fee-toxed.

Restrictions placed on acquisition of phase levels because of marijuana use frustrated many of my clients without any real medical justification (Epstein and Preston 2003; SAMHSA 2005). Restriction of dose levels because of benzodiazepine use put MMT clients in my sample at risk of withdrawal and further illicit drug use. While there are medical justifications for restrictions resulting from benzodiazepine use due to potentially harmful drug interactions, this potential harm must be weighed against the definite harm of negating one of the primary purposes of MMT, relieving the pain of withdrawal (SAMHSA 2005).

A comment I've heard from Blake numerous times at HRAC was, "If they'd just follow the SAMHSA protocols it'd be a way better system." The protocols Blake was referring to are SAMHSA's Treatment Improvement Protocols 43, a 358-page guide to optimizing MMT and other opiate replacement therapies. TIP 43 explicitly calls for comprehensive treatment along side MMT – assessing MMT clients' other needs, psychological, medical and socioeconomic, and referring them to the appropriate agencies

(2005). The problem with comprehensive treatment along side MMT is the same problem we find with fee-tox - there just isn't funding available. There are things that MMT could do even without additional funding such as collaborating more with primary care physicians and advocating for clients/referring them to medical treatment. Two of my respondents talked about methadone helping them with pain management. Both also said that pain management was a part of the reason they had used heroin but their doctors at OBHS refused to discuss pain management with them. Jim said that the OBHS doctor he spoke with told him OBHS is a methadone clinic and they don't deal with pain. Neither thought to ask for collaboration with their primary care physicians on a higher methadone dose to facilitate pain management because neither has a primary care physician. On other issues such as housing and mental health, availability of services is limited. There is little that the clinics could do to refer their clients to services that are either unavailable to low-income persons or are overburdened and have long waiting lists.

When it comes to fee-tox, there are only two agencies in Denver that deal with financial assistance for paying MMT fees and one of those is limited to a one-time emergency payout of less than half of a month's MMT fees at the cheapest clinic. That leaves one organization which prioritizes intake costs, then fee-tox situations, then – if there is any funding left over – assistance for regular fee payments on a first come first serve basis. This is an organization that Blake works with. During our interview she said that she could also sometimes push back the initiation of fee-tox by calling clinics to advocate for clients who come to her but much more needs to be done.

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